Midwest Digestive Health and Nutrition
900 Rand Road Suite 120
Des Plaines, IL 60016
Phone: 312-767-3244
Fax: 708-795-9598

Authorization to Release Medical Records

Section A: Individual For Whom Medical Records Are Being Requested

First Name: _____ Middle Name: _____ Last Name: _____

Previous Name (if applicable): _____

Street Address: _____ Date of Birth: _____

City/State/Zip: _____ Daytime phone number: _____

Section B: Person or Organization From Whom Medical Records Are Requested.

Hospital/agency/clinic/physician: _____

Address: _____

Phone: _____ Fax: _____

Section C: Send Requested Medical Information To:

Midwest Digestive Health and Nutrition
ATTN: _____
Address: 900 Rand Road Suite 120 Des Plaines, IL 60016

Phone: 312-767-3244
Fax: 708-795-9598

Section D: Information To Be Disclosed From DATE (or RANGE OF DATES) Date: _____

Check information needed

- ☐ History and Physical
- ☐ Physician's Discharge Summary
- ☐ Emergency Department Record
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Alcohol/substance Abuse
- ☐ Rehab Records
- ☐ Social History
- ☐ HIV/AIDS
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Outpatient Notes (pre/post hospitalization)
- ☐ Developmental Disabilities Records
- ☐ Behavior Plans
- ☐ Mental Health Record
- ☐ Other _____

Section E: Expiration of Authorization

This authorization is valid until calendar date: Month/Day/Year: _____
Unless an earlier date is specified, this authorization will expire 12 months from date of signature below.

Section F: Signature

a. If the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described in Section D may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from re-disclosing mental health, developmental disability, substance abuse or AIDS related information under the Federal Substance Abuse Act 42CFR Part 2, Confidentially Requirements of the Illinois Mental Health and Development Disabilities Confidentiality Act and the Illinois AIDS Confidentiality Act.
b. The person I am authorizing to use the information may receive compensation for doing so.
c. I may inspect and copy the information disclosed.
d. Payment of a claim, enrollment, and eligibility for benefits will not be affected if I do not sign this form unless the disclosures are necessary to determine payment, eligibility, or enrollment, or for disability re-determinations.
e. I may revoke this authorization at any time. The revocation must be in writing and must be sent/given to the records department named in Section B. It will not affect action already taken before the revocation is received.

Signature of Individual: _____ Date: _____

Signature of Representative: _____ Date: _____

Authority to represent individual: ___ Parent ___ Guardian ___ Power of Attorney ___ Authorized Representative

Signature of Witness (or guardian): _____ Date: _____

Section G: Revocation Section. If completed, send copy of entire form to person or organization named in Section B.

I no longer want health information pertaining to the person named in Section A shared with Midwest Digestive Health and Nutrition. I understand action already taken before the revocation is received is not affected.

_____ _____

Signature of Individual or authorized representative *Date:*

Authority to represent individual: ___ Parent ___ Guardian ___ Power of Attorney ___ Authorized Representative